SECTION 12 - SOCIAL WELFARE PROGRAMS IN THE TERRITORIES

CONTENTS

COVERAGE AND PARTICIPATION IN SELECTED PROGRAMS

Most social welfare programs available in the 50 States and the District of Columbia are also available in the United States territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.[1] Social welfare programs discussed in this chapter provide retirement and disability benefits, financing of health care, unemployment compensation, public assistance for low-income persons or families, education benefits, job training, and social services.

[1] This section discusses the availability of social programs in the five major territories and provides an overview of special rules that apply in the territories. It does not discuss Federal financial assistance for three areas that were formally part of the trust territories and are now independent in "free association" with the United States: the Marshall Islands, the Federated States of Micronesia, and Palau. These areas remain eligible for some residual aid from the United States.

For the purposes of this section, Federal social welfare programs are divided into two categories:

1. *Federal Programs that Make Direct Payments to Individuals*--These programs have Federal eligibility and benefit rules and are administered directly by the Federal government.[2]

2. *Federal-State Programs*--For these programs, States, and in some cases localities, have a role in the design, administration, and often financing of benefits and services. For the territories to participate in the joint Federal-State programs, Federal law must make them eligible and the territory's government must act to meet conditions for Federal assistance. Table 12-1 shows the current coverage of residents of the territories by selected social welfare programs directly administered by the Federal government.

TABLE 12-1--COVERAGE OF RESIDENTS OR WORKERS IN THE TERRITORIES FOR SELECTED SOCIAL WELFARE PROGRAMS MAKING DIRECT PAYMENTS FOR INDIVIDUALS

Program	American Samoa	Guam	Northern Mariana Islands	Puerto Rico	U.S. Virgin Islands
Social Security (Retirement, Survivors and Disability Insurance)	Yes	Yes	Yes	Yes	Yes
Medicare	Yes	Yes	Yes	Yes	Yes
Supplemental Security Income (SSI)	No	No	Yes	No	No
Guaranteed Student Loans	Yes	Yes	Yes	Yes	Yes
Pell Grants	Yes	Yes	Yes	Yes	Yes

Source: Congressional Research Service (CRS).

Table 12-2 summarizes the availability in each territory of major social programs that are operated jointly by the Federal government and the territories. Coverage under the Unemployment Compensation program is determined in the Federal Unemployment Tax Act (FUTA), which applies to Puerto Rico and the U.S. Virgin Islands but not the other territories. Though coverage is determined in FUTA, program design is left to the territory. The Food Stamp program[3] operates only in Guam and the U.S. Virgin Islands with special grant programs

[2] This chapter's classification of programs making "direct" payments to individuals differs from that found in Federal budget documents and the Census Bureau published Consolidated Federal Funds Report. This chapter classifies unemployment compensation as a Federal-State program because States administer and design their own programs within Federal guidelines. Unemployment Compensation is not a grant-in-aid program, so that other documents classify it as a direct payment to individuals. The Food Stamp program is also classified as a Federal-State program because it is administered by the States.

[3] Section 4001 of the Food, Conservation and Energy Act of 2008 (Public Law 110-234) changed the name of the Food Stamp program to the Special Nutrition Assistance Program (SNAP). Additional information on the SNAP program can be found in Section 15 of this publication. For the purposes of this section, the program will be referred to as the "Food Stamp program."

to provide food assistance operating in American Samoa, the Northern Mariana Islands and Puerto Rico. All of the territories are eligible to participate in the Special Supplemental Food Program for Women, Infants and Children (WIC), however, the Northern Mariana Islands does not elect to participate in this program.

Most Federal-State social welfare programs other than those discussed above are grant-in-aid programs by which the Federal government helps finance benefits and services in State or local programs. Territories, like States, may choose not to participate in grant programs. Participation in a program entails accepting Federal rules and guidelines and in some cases providing State or local dollars to match Federal dollars.

Table 12-2 shows whether Federal law makes the territory eligible to participate in a given program and whether the territory participated in the program in fiscal year 2008.

TABLE 12-2--ELIGIBILITY FOR SELECTED FEDERAL-STATE SOCIAL WELFARE PROGRAMS IN THE TERRITORIES, Fiscal Year 2008

	American Samoa		Guam		Northern Mariana Islands		Puerto Rico		U.S. Virgin Islands	
Program	Eligible	Participating	Eligible	Participating	Eligible	Participating	Eligible	Participating	Eligible	Participating
Unemployment Compensation	No	NA	No	NA	No	NA	Yes	Yes	Yes	Yes
Public Assistance and Related Programs:										
Temporary Assistance for Needy Families (TANF)	Yes	No	Yes	Yes	No	NA	Yes	Yes	Yes	Yes
Aid to the Aged, Blind, or Disabled	No	NA	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Child Support Enforcement	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Foster Care and Adoption Assistance	Yes	No	Yes	No	No	NA	Yes	Yes	Yes	No
Medical Assistance[1]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Social and Support Services:										
Child Care and Development Block Grant (CCDBG)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Social Services Block Grant	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Older Americans Act	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Food and Nutrition Assistance:										
Food Stamp Program	No	NA	Yes	Yes	No	NA	No	NA	Yes	Yes
Special Supplemental Food Program for Women, Infants and Children (WIC)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Education and Training[2]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Child Protection:										
Child Welfare Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Promoting Safe and Stable Families	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Child Abuse Prevention and Treatment Act (CAPTA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

[1] "Medical Assistance" includes Medicaid, State Children's Health Insurance Program (SCHIP), and the Maternal and Child Health Block Grant.

[2] "Education and Training" includes Compensatory Education for the Disadvantaged and Workforce Investment Act programs.

NA- Not applicable.

Source: Congressional Research Service (CRS).

EXPENDITURES FOR SELECTED MAJOR SOCIAL WELFARE PROGRAMS IN THE TERRITORIES

Table 12-3 shows Federal expenditures for selected major social welfare programs in the territories. For some Federal-State programs, such as Medicaid, State Children's Health Insurance Program (SCHIP), child support, and the programs for the aged, blind, or disabled, the table shows the Federal share of expenditures. For programs in which the territories are required to match Federal expenditures with their own funds, the territory's match is not shown. For programs that make direct payments to individuals such as Social Security and Medicare, Federal outlays represent the total amount spent by the program in the territories.

TABLE 12-3--FEDERAL FUNDING FOR SELECTED MAJOR SOCIAL WELFARE PROGRAMS IN THE TERRITORIES, Fiscal Year 2007

[In Thousands of Dollars]

	American Samoa	Guam	Northern Mariana Islands	Puerto Rico	U.S. Virgin Islands
Social Insurance:					
Social Security (Retirement, Survivors, and Disability Insurance)	$39,344	$146,880	$14,577	$5,870,777	$167,804
Medicare (Parts A and B)	[1]	1,802	[1]	2,016,188	31,988
Unemployment Compensation	NA	NA	NA	200,777	7,488
Public Assistance:					
Supplemental Security Income (SSI)	NA	NA	4,526	NA	NA
Aid to the Aged, Blind, or Disabled	NA	1,221	NA	47,338	664
Temporary Assistance for Needy Families (TANF)	NA	4,040	NA	102,443	[1]
Child Support Enforcement	NA	3,658	NA	34,894	[1]
Foster Care and Adoption Assistance	NA	NA	NA	14,172	NA
Health Care for Low-Income Persons and Families:					
Medicaid	8,496	13,096	4,659	291,116	[1]
State Children's Health Insurance Program (SCHIP)	630	1,838	578	48,090	[1]
Social and Support Services:					
Social Services Block Grants[2]	49	293	[1]	8,793	293
Child Care and Development Block Grant (CCDBG)[2]	2,606	4,048	[1]	34,860	[1]
Older Americans Act (Titles III and VII)[2]	1,332	2,903	[1]	13,944	2,828
Nutrition Assistance:					
Food Stamp Program	NA	55,695	NA	NA	21,028
Nutrition Assistance[2]	4,650	NA	9,441	1,526,167	NA
Special Supplemental Food Program for Women, Infants and Children (WIC)	6,821	7,635	NA	207,869	5,901

[1] Less than $500 in reported expenditures or data is not available.

[2] Grant award or obligations rather than expenditures.

Source: Bureau of the Census, 2007 Consolidated Federal Funds Report Online Query System available on the website of the Bureau of the Census at http://harvester.census.gov/cffr/.

SPECIAL RULES

SUPPLEMENTAL SECURITY INCOME (SSI) COVERAGE

The Social Security Amendments of 1972 (Public Law 92-603) ended matching grant programs to the 50 States and the District of Columbia for assistance to needy adults who are aged, blind, or disabled and replaced them with Supplemental Security Income (SSI). The new SSI Program provided a Federal entitlement program of cash payments for individuals in these groups.

While SSI was later extended to the Northern Mariana Islands, SSI was not extended to Guam, Puerto Rico and the U.S. Virgin Islands. The previous grant programs for the aged, blind or disabled that were authorized under four separate titles of the Social Security Act continue in these territories.[4] American Samoa does not participate in either the SSI or aid to the aged, blind or disabled programs. While SSI benefits are set by the Federal government and subject to State supplementation, the amounts of aged, blind, or disabled benefits are set by the territories.

NUTRITION ASSISTANCE BLOCK GRANT FOR PUERTO RICO AND GRANTS FOR AMERICAN SAMOA AND THE NORTHERN MARIANA ISLANDS

The Food Stamp program operates only in Guam and the U.S. Virgin Islands. These territories are considered "States" for the purposes of this program; although some slightly different rules apply in calculating benefits (see the section of the Green Book covering the Food Stamp program for these differences). Restrictions on the eligibility of noncitizens under the Food Stamp program apply in Guam and the U.S. Virgin Islands.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) replaced the regular Food Stamp program in Puerto Rico with a special Nutrition Assistance Block Grant. Puerto Rico was given almost complete authority in designing its program within the funding provided by the block grant (an indexed amount standing at $1.395 billion in fiscal year 2003): Puerto Rico's eligibility standards and benefit levels are lower than for the Food Stamp program; instead of requiring that all benefits be spent on food items, Puerto Rico earmarks 75 percent of benefits specifically for food; and restrictions on the eligibility of legally resident noncitizens established for the Food Stamp program do not apply.

American Samoa and the Northern Mariana Islands also receive nutrition assistance grants. American Samoa receives an indexed grant amount and operates a program limited to helping low-income aged and disabled persons. The Northern Mariana Islands receives a periodically negotiated grant and operates a program much like the Food Stamp program; although with lower eligibility standards and benefits and a requirement that a portion of benefits be spent on locally produced foods. Restrictions on the eligibility of legally resident noncitizens established for the Food Stamp program do not apply in American Samoa or the Northern Mariana Islands.

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[4] Title I, Grants to States for Old-Age Assistance for the Aged; Title X, Grants to the States for Aid to the Blind; Title XIV, Aid to the Permanently and Totally Disabled; and Title XVI, Grants to the States for Aid to the Aged, Blind, or Disabled.

HEALTH PROGRAMS

MEDICAID

Financing

In the 50 States and the District of Columbia, Medicaid[5] is an individual entitlement. There are generally no limits on Federal payments for Medicaid provided the State is able to contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. Table 12-4 shows Medicaid caps for fiscal years 1983-2008 for each of the territories.

Congress has increased the levels of Federal Medicaid funding in the territories in recent years. In the 108th Congress, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, Public Law 108-27) provided temporary fiscal relief for States and local governments through a combination of direct grants and increases to the Federal Medicaid matching rate known as the Federal Medical Assistance Percentage (FMAP), which determines the share of Medicaid expenditures paid for by the Federal government. To accommodate the FMAP increase included in JGTRRA, caps that apply to Federal Medicaid spending in the territories were raised by 5.9%.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Public Law 108-173) added a new Medicare prescription drug benefit, which was implemented in January 2006. In lieu of the premium and cost sharing subsidies available for qualified enrollees, MMA allowed each of the territories to submit a plan to the Secretary of Health and Human Services to obtain a share of additional funds in the form of additional Medicaid funding for low-income individuals covered by Part D drugs. Territories with approved plans receive an increase in their share of grant funding paid under Section 1935(e). MMA specified grant amounts for each of the territories for a portion of fiscal year 2006 and for fiscal year 2007. For fiscal year 2008 and subsequent fiscal years, the fiscal year 2007 amount is increased by the annual percentage increase on Part D spending (see Table 12-4 for Section 1935(e) grant fund totals). In the 109th Congress, the Deficit Reduction Act of 2005 (DRA, Public Law 109-171) increased the Federal Medicaid funding caps by 8.9% (in fiscal year 2006) and 8.3% (in fiscal year 2007) over the fiscal year 2005 levels. For fiscal year 2008 and subsequent fiscal years, the total annual cap on Federal funding for the Medicaid programs in the territories is calculated by increasing the fiscal year 2007 ceiling for inflation.

The FMAP ranges from 50% to 83% in the 50 States and the District of Columbia. The FMAP rate for the 50 States and the District of Columbia is based on a formula that provides higher reimbursement to States with lower per capita incomes relative to the national average (and vice versa). In the

[5] Medicaid program descriptions based on information provided by the Centers for Medicare and Medicaid Services, Office of Legislation and Planning, June 2008.

territories, by contrast, the FMAP is statutorily set at 50%. The Federal statute also affects the ability of the territories to access certain sources of Medicaid funding. For example, when establishing hospital payment rates, State Medicaid programs are required to recognize situations in which hospitals provide a disproportionate share of care to low-income patients with special needs. Such "disproportionate share (DSH) payments" are subject to Statewide allotment caps, and DSH has become a key source of Medicaid funding for safety net hospitals. In 2006, the most recent year for which data were available, total reported DSH payments were $17.1 billion, or 5% of all Federal Medicaid spending to the States.[6] The territories, by contrast, were not included in the Federal legislation that established the Medicaid disproportionate share hospital program. The territories have access to other sources of Federal matching funds, for example, they may be eligible for enhanced Federal match (90% or 75%) that is available under Medicaid for improvements in data reporting systems. However, because funds spent on these administrative activities would also count against the Medicaid caps, the territories reportedly do not utilize these financing arrangements so as not to divert funds from providing direct care to beneficiaries.

Despite the recent increases in Federal funding in the territories, some argue that the funding levels are insufficient. The Centers for Medicare and Medicaid Services (CMS) confirm that all five of the territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid State plan services or in some instances may suspend services or cease payments to providers until the next fiscal year.[7] The territories reportedly submitted their entire universe of Medicaid expenditures on the fiscal year 2006 CMS form 64[8] despite the fact that CMS only grants awards up to the Federal ceiling limits in order to provide CMS with information as to the sufficiency of statutory limits.[9] However, because eligibility and covered services are also limited in part as a result of the Medicaid caps, these reported expenditures may not fully measure the adequacy of the statutory limits (see Table 12-4 for fiscal year 2008 expenditure estimates of territory-only funds directed at the Medicaid programs in the territories).

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[6] 2006 CMS form 64 data—net reports.

[7] Government Accountability Office, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, (Washington: GPO 2005).

[8] CMS form 64 is used by State Medicaid agencies to report their program benefit costs and expenses to CMS.

[9] In fiscal year 2006, Puerto Rico (in particular) reported almost double in actual Medicaid expenditures than they have authority to spend under their Medicaid cap. By contrast, the other territories reported Federal Medicaid expenditures for fiscal year 2006 that are above - but still fairly close - to their caps.

TABLE 12-4--MEDICAID FEDERAL SHARE LIMITS, Fiscal Years 1983-2008 [In Thousands of Dollars]

	American Samoa		Guam		Northern Mariana Islands		Puerto Rico		U.S. Virgin Islands	
Fiscal Year	Statutory Cap	§1935(e) Cap	Statutory Cap	§1935(e) Cap	Statutory Cap	§1935(e) Cap	Statutory Cap	§1935(e) Cap	Statutory Cap	§1935(e) Cap
1983	$750		$1,400		$350		$45,000		$1,500	
1984-1987	1,150		2,000		550		63,400		2,100	
1988	1,330		2,320		637		73,400		2,430	
1989	1,390		2,410		693		76,200		2,515	
1990-1993	1,450		2,500		750		79,000		2,600	
1994	2,140		3,685		1,110		116,500		3,837	
1995	2,240		3,870		1,160		122,200		4,030	
1996	2,350		4,060		1,220		128,100		4,220	
1997	2,440		4,210		1,270		133,000		4,380	
1998	3,010		5,090		1,810		167,000		5,260	
1999	3,090		5,230		1,860		171,500		5,400	
2000	3,200		5,410		1,930		177,500		5,590	
2001	5,620		5,620		2,010		184,400		5,810	
2002	3,470		5,880		2,100		192,900		6,080	
2003 w/JGTRRA	3,727		6,321		2,255		207,341		6,537	
2004 w/JGTRRA	3,947		6,683		2,381		219,397		6,913	
2005	3,950		6,690		2,380		219,600		6,920	
2006 w/DRA	6,120	$157	9,480	$447	3,480	$62	241,000	$26,888	9,720	$570
2007 w/DRA	8,290	206	12,270	612	4,580	85	250,400	35,822	12,520	775
2008	8,620	212	12,760	637	4,760	90	260,400	37,469	13,020	833

JGTRRA = The Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, Public Law 108-27) provided temporary fiscal relief for States and local governments through a combination of FMAP increases and direct grants. To accommodate the FMAP increase, caps that apply to Federal Medicaid spending in the territories were raised by 5.9%.

DRA = The Deficit Reduction Act of 2005 (Public Law 109-171) increased the Federal Medicaid funding caps by 8.9% (in fiscal year 2006) and 8.3% (in fiscal year 2007) over the fiscal year 2005 levels.

§1935(e) = The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Public Law 108-173) added a new Medicare prescription drug benefit, which was implemented in January 2006. In lieu of the premium and cost sharing subsidies available qualified enrollees, MMA allowed territories with approved plans to receive an increase in their share of grant funding paid under Section 1935(e).

Note: The Medicaid statutory limits do not apply to Federal payments with respect to: Section 1935(e) of the Social Security Act (the Act)- Medical assistance with respect to providing prescription drugs to Part D eligibles under an approved plan (began January 2006); Section 1931(h) of the Act- Allocations of enhanced Federal matching funds for increased administrative costs resulting from welfare reform; or Section 1905(u)(2) and (u)(3) of the Act- Eligibles under an approved SCHIP plan.

Source: Table prepared by CRS based on data provided by the Centers for Medicare and Medicaid Services (CMS).

TABLE 12-5--MEDICAID ELIGIBILITY STANDARDS AND ENROLLMENT ESTIMATES AND TERRITORY-ONLY FUNDED ELIGIBILITY STANDARDS, ENROLLMENT AND EXPENDITURE ESTIMATES IN THE TERRITORIES, JUNE 2008

	Medicaid			Territory-only Funded Program		
	Eligibility Criteria		Fiscal Year 2008 Enrollment Estimates	Eligibility Criteria (annual income for a family of 4)	Fiscal Year 2008 Point-in-time Enrollment Estimates	Fiscal Year 2007 Expenditure Estimates
Territory	Categorical[1]	Financial[2] (annual income for a family of 4)				
American Samoa	No specific categories	At or below $42,400	60,864	Not Applicable		$1,709,408
Guam	Categorically needy	$21,200	29,625	Medically Indigent Program (MIP) covers low-income individuals who are not eligible for Medicaid; children in foster care; and individuals with tuberculosis, bodig, lyticos, leprosy, and end-stage renal disease, and insulin-dependent diabetes.		
				$21,412 up to and including $63,600[3]	29, 265	$1,536,144
Northern Mariana Islands	Individuals eligible for SSI and individuals with total income that does not exceed 150% of the SSI Federal benefit amount and allowable resource limit	The Federal benefit rate is $11,466 per year for an individual with an allowable resource limit of $2,000	11,292	Not Applicable		$305,686
Puerto Rico	Categorically needy	$8,220[4]	883,370	$16,440	317,433	$672,418,015
	Medically needy	$16,440[4]				
U.S. Virgin Islands	Categorically needy	$3,156	6,668	Not Applicable		
	Medically needy	$8,500				

[1] In general, the Medicaid statute limits the categories of individuals that can be covered and establishes specific eligibility rules for groups within those broad categories. The two broad categories described in statute are categorically needy and medically needy. Categorically needy refers to low-income families and children, aged, or individuals who are blind or have a disability, and certain pregnant women who are eligible for Medicaid. Medically needy individuals are persons who fall into one of the categorically needy groups but whose income and resources are too high to qualify as categorically needy as provided by 42 CFR §435.4.

[2] Medicaid is a means-tested program. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions. States are generally required to exclude certain types and amounts when they determine countable income for any Medicaid eligibility pathway, other income exclusions and disregards may be applied at State option.

[3] Medical assistance for foster care children is extended without regard to income and resources. For all other groups, $2,000 in resources is disregarded in determining eligibility, and the territory applies disregards for property and a vehicle. Beneficiary cost sharing rules apply.

[4] Data made available by the Medicaid Director of Puerto Rico's Office for the Medically Indigent, July 9, 2008.

Source: Table prepared by CRS based on data from the Centers for Medicare and Medicaid Services (CMS), June 2008.

Administration of Medicaid Programs in the Territories

The territories operate their Medicaid programs under rules that differ from those that apply to the 50 States and the District of Columbia. They are not required to cover the same eligibility groups, and they use different financial standards (income and assets tests) in determining eligibility (Table 12-5 shows Medicaid categorical and financial eligibility standards in the territories as of June, 2008). For example, Medicaid requires States to cover certain mandatory eligibility groups such as poverty-related pregnant women and children, Qualified Medicare Beneficiaries (QMBs), and specified low-income Medicare beneficiaries (SLMBs).[10] For the territories, however, coverage of these groups is optional. In addition, because the territories must operate their programs under funding caps, CMS is more flexible in oversight of required services. For example, none of the territories cover all mandatory services.[11,12] The territories

[10] Qualified Medicare Beneficiaries (QMBs) refers to one of Medicaid's categorical eligibility groups. This group includes individuals who are aged or disabled Medicare beneficiaries with annual income no greater than 100 percent of the Federal poverty level (FPL), and assets no greater than $4,000 for individuals or $6,000 for couples. Specified low-income Medicare beneficiaries meet QMB criteria, except that their incomes are greater than 100 percent of FPL, but do not exceed 120 percent of FPL. Specified low-income Medicare beneficiaries (SLMB) are persons eligible for Medicare Part A benefits and whose income is between 100% and 120% of the FPL and who have limited assets.

[11] The Medicaid statute identifies the services States must cover as well as those that may be covered at the State's option. Services are grouped under broad categories which may include several specific types of services. The statute also requires States to provide specific services to certain eligibles. Specifically, Federal law distinguishes between individuals who are "categorically needy" versus "medically needy." Most eligibility groups (both mandatory and optional) qualify as categorically needy. The medically needy group includes individuals who would be a member of one of the broad Medicaid groups (i.e., are aged, have a disability or are in families with children), but have higher income or resources. The distinction between categorically needy and medically needy has become somewhat outdated, but it continues to be important in identifying mandatory versus optional services because of the way in which the Medicaid statute is written. For example, inpatient hospital services are a mandatory service for categorically needy individuals, but for medically needy individuals they are only mandatory if they are pregnancy-related. Because the territories do not follow the same eligibility-related rules as are present in the 50 States and the District of Columbia, it is difficult to determine what services would be considered mandatory in the territories.

[12] In an October 2005 publication (Government Accountability Office, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, (Washington: GPO 2005)), the Government Accountability Office (GAO) reported that several of the Medicaid mandatory services were *not* covered, or were covered with limitations. GAO's summary of covered Medicaid services was based on conversations with territorial officials and data from the August 2005 Kaiser Commission on Medicaid and the Uninsured Medicaid Benefits Database. In their publication GAO reported, "CMS is aware that the insular areas do not provide all mandatory Medicaid services. However, according to a CMS official, the agency does not have any guidance as to how it should ensure compliance with the Federal Medicaid standards regarding mandatory services, especially in light of limits on Federal funding in the insular areas. Over time, CMS has allowed the insular areas to determine which Medicaid services they provide to maximize their use of Federal health care funds." In fiscal year 2008, the CMS Office of Legislation and Planning acknowledged that they are "flexible" in their oversight of Medicaid benefit requirements in the territories (including requirements regarding the coverage of Medicaid mandatory services). When asked about the confusion that may result when attempting to determine which services are considered mandatory in the territories since they do not follow the same eligibility-related rules as the 50 States and the District

are also exempt from the requirement to offer program beneficiaries freedom of choice of providers.

However, the territories are required to meet certain rules that also apply to the States. For example, with regard to rules about amount, duration, and scope of covered services, the territories must meet the same standards that apply to the States and the District of Columbia provided these jurisdictions are using Federal matching payments for their services. Table 12-6 shows a list of selected mandatory services that were covered by the Medicaid programs in the territories in fiscal year 2005 (the most recent year available). Table 12-7 provides a list of optional Medicaid services that were covered by the Medicaid programs in the territories in fiscal year 2008. A brief summary of each territory's Medicaid program is provided below.

American Samoa-The Medicaid program in American Samoa has operated under a Section 1902(j) waiver since January 29, 1983. In American Samoa Medicaid eligibility determinations are based on a system called "presumptive eligibility."[13] Annually, American Samoa estimates the number of individuals who fall below an estimated needs or poverty level. Individuals whose incomes fall below this level are determined to be poor and thus are eligible for the territory's Medicaid program. The poverty level for American Samoa is computed by multiplying the poverty level for the United States, as determined by the Office of Management and Budget (OMB), by the lower of (1) the ratio of American Samoa's median income to the U.S. median income, or (2) the ratio of American Samoa's median income to that of the State receiving the highest Medicaid FMAP rate, and then adjusting this amount by a deflation factor. The number of persons "presumed eligible" is determined by comparing census data, previous year tax returns, or survey data with the estimated poverty level. In 2006, American Samoa increased its Medicaid eligibility from 100% of the Federal poverty level (FPL) to 200% FPL. Under this eligibility change, the Medicaid program estimates that 88% of the total population will be eligible for Medicaid (see Table 12-5).

Coverage of some Medicaid services is only available off-island. These include nursing facility services for individuals age 21 and older; home health services for individuals eligible for nursing facility services; medical or other remedial care provided by licensed practitioners; private duty nursing; occupational therapy; and speech, language, and hearing therapy. Off-island services are generally provided in Hawaii, or occasionally in other States

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of Columbia, CMS reported that each of the territories provide coverage for all of the Medicaid mandatory services.

[13] Presumptive eligibility under Medicaid and the State Children's Health Insurance Program (SCHIP) normally means a period of time for which a person is "presumed eligible" for Medicaid or SCHIP benefits. During this time, services may be rendered and billed to the Medicaid or SCHIP program with the understanding that an official eligibility determination will be made and the beneficiary will be properly enrolled shortly after receiving services. American Samoa uses the term "presumptive eligibility" to refer to its process for setting its income eligibility limit for coverage under its Medicaid program.

provided funds are available. Medical necessity for off-island care is determined by the admitting physician, and approval of off-island care is made by physicians on the Off-Island Medical Referral Committee. For a list of selected Medicaid mandatory and optional services covered by the Medicaid program in American Samoa see Tables 12-6 and 12-7. Medicaid enrollment estimates for American Samoa totaled approximately 60,864 in FY2008 or approximately 89% of its total population.

Guam- Guam's Medicaid program is administered by the territory's Department of Public Health and Social Services, Bureau of Health Care Financing. Guam claims Federal funds for covered services to certain categorically needy individuals that meet an income eligibility threshold of 100 percent of the FPL (see Table 12-5). Medicaid's poverty-related groups and Qualified Medicare beneficiaries (QMBs) are not eligible. The medically needy were included until October 1984, but in subsequent years have been covered with territory-only funds. Guam pays Medicare premiums for individuals entitled to both Medicare and Medicaid. Guam does not have an SSI program, but SSI-related eligibility groups such as old-age assistance, aid to the blind, aid to the permanently and totally disabled exist.

For a list of selected Medicaid mandatory and optional services covered by the Medicaid program in Guam see Tables 12-6 and 12-7. When these services are not available on Guam, but are medically necessary, off-island services including transportation are provided. Almost all patients are sent to Hawaii, or occasionally to California. All off-island care, except emergency care, must be pre-approved and is based on negotiated rates. Exclusions to off-island care include services such as elective cosmetic surgery, experimental treatments, fertility procedures, sterilizations, abortions, and organ transplants. Guam's Medicaid enrollment was approximately 29,625 in fiscal year 2008. This represents approximately 17% of the total island population in that year.

Northern Mariana Islands-The Northern Mariana Islands Medicaid program has operated under a Section 1902(j) waiver of the Social Security Act since October 1, 1989.[14] The program is administered by the territory's Department of Public Health Services. The Northern Mariana Islands is the only territory which has SSI, and its entire Medicaid program is based on SSI requirements. All individuals receiving SSI cash payments are eligible for Medicaid after submission of an application. Anyone else who meets the income and resource standards for SSI (with the standard income exemptions and deductions) is also eligible. The Northern Mariana Islands pays Medicare premiums for individuals who are dually eligible for Medicare and Medicaid. Although the Northern Mariana Islands does not have a medically needy

[14] Section 1902(j) refers to the section of the Social Security Act under which authority is granted to waive certain Medicaid program rules. Under a Section 1902(j) waiver, the only Medicaid requirements that may not be waived include: (1) the 50 percent Federal medical assistance percentage (FMAP); (2) the capped Medicaid allotments for Guam; and (3) payment may not be made for services that are not described in Section 1905(a) of the Social Security Act.

program as such, individuals can spend down to become eligible for any month in which medical costs reduce income to the commonwealth's Medicaid eligibility threshold (see Table 12-5).

For a list of selected Medicaid mandatory and optional services covered by the Medicaid program in the Northern Mariana Islands, see Tables 12-6 and 12-7. Nursing facility care and home health services are only covered on an off-island basis. For medically necessary care that cannot be provided in the Northern Mariana Islands, patients may be sent to Guam, Hawaii, or occasionally other States-- generally to California-- for care. The Northern Mariana Islands Medical Referral Office negotiates all-inclusive per diem rates for specific off-island services generally at the rate paid by the local Medicaid program. Medicaid enrollment estimates for the Northern Mariana Islands totaled approximately 11,292 in fiscal year 2008 or approximately 13% of its total population.

Puerto Rico- In 1994, Puerto Rico established a new public agency, the Puerto Rico Health Insurance Administration, for the purpose of implementing "Reforma," a privatized, island-wide, managed care delivery system. Medicaid services in the commonwealth of Puerto Rico are covered under Reforma. Once the commonwealth has spent all of its combined Medicaid and SCHIP capped allotments, care provided through the Medicaid program is completely funded by territory-only dollars.[15] In addition, the commonwealth utilizes a "Catastrophic Fund" (consisting of territory-only funds) to provide certain types of off-island care for Reforma enrollees.

Puerto Rico uses its own poverty level (the commonwealth poverty level) to determine eligibility for the program. The commonwealth poverty level of $8,220 per year for a family of four is substantially lower than the mainland level and has not changed since 1998.[16] Medicaid eligibility determinations are made by the Office of Economic Assistance to the Medically Indigent, Puerto Rico Department of Health. The Medicaid program in Puerto Rico extends coverage to children, pregnant women, and adults in families with children, the elderly and individuals with disabilities. Puerto Rico does not have an SSI program, but SSI-related eligibility groups such as Old-Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, and so forth exist. Qualified Medicaid Beneficiaries (QMBs), and Specified Low Income Medicare Beneficiaries (SLMBs) are not covered under the commonwealth's Medicaid program (See Table 12.5).[17]

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[15] The income eligibility standard for Puerto Rico's territory-only funded program is $16,440 (annually) for a family size of four.

[16] In 2008, the poverty guideline in the 48 contiguous States and the District of Columbia is $10,400 for an individual, and $21,200 for a family of four. ("Annual Update of the HHS Poverty Guidelines," 73 *Federal Register* 15, January 23, 2008).

[17] Information made available by the Medicaid Director of Puerto Rico's Office for the Medically Indigent from July 9, 2008.

The commonwealth covers most Medicaid mandatory services, with the exception of services related to long term care,[18] as well as several optional services. For a list of selected Medicaid mandatory and optional services covered by the Medicaid program in Puerto Rico, see Tables 12-6 and 12-7. Under certain circumstances, Puerto Rico may provide Medicaid services off-island.[19] Puerto Rico's Medicaid enrollment was approximately 883,370, which is approximately 23% of its total population in FY2008.

U.S. Virgin Islands-The U.S. Virgin Islands Medicaid program is administered by the territory's Bureau of Health Insurance and Medical Assistance under the Virgin Islands Department of Health. The program covers categorically needy and medically needy individuals including children, pregnant women, adults in families with children, the elderly, and individuals with disabilities. Like several of the other territories, the U.S. Virgin Islands *does not* cover poverty-related groups. The U.S. Virgin Islands does not have an SSI program, but eligibility classifications of aid to the blind, old-age assistance and aid to the permanently and totally disabled exist. In the U.S. Virgin Islands Medicaid pays Medicare premiums for individuals dually eligible for Medicare and Medicaid. In fiscal year 2008, the categorically needy standard for a family of four was $3,156, and the medically needy standard for a family of four was $8,500. In counting annual income to determine eligibility for Medicaid, certain income disregards are applied (See Table 12-5).

For a list of selected Medicaid mandatory and optional services covered by the Medicaid program in Puerto Rico, see Tables 12-6 and 12-7. Medicaid beneficiaries requiring services that are not available on the island are sent to Puerto Rico or other States for care. Medicaid enrollment estimates in the Virgin Islands totaled approximately 6,668 in fiscal year 2008. This represented approximately 6% of the total island population in that year.

[18] Information made available by the Medicaid Director of Puerto Rico's Office for the Medically Indigent from July 9, 2008.
[19] Off-Island care may be provided in accordance with the requirements of 42 CFR § 431.52.

TABLE 12-6--SELECTED MANDATORY MEDICAID SERVICES COVERED BY THE TERRITORIES, Fiscal Year 2005

Covered Service	American Samoa	Guam	Northern Mariana Islands	Puerto Rico	U.S. Virgin Islands[1]
Inpatient Hospital	●	●	●	●	●
Outpatient Hospital	●	●	●	●	●
Physician's Services	●	●	●	●	●
Laboratory and X-ray	●	●	●	●	●[2]
Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Individuals Under Age 21	●	●	●	●	●
Family Planning Services and Supplies	●	●	●	●	●
Transportation	●	○	●	◘[3]	◘[4]
Certified Nurse Practitioner	○	●	○[5]	○	◘[6]
Home Health	◘	○	●	○	●
Federally-qualified Health Center (FQHC)	○	○	○	●	●
Nursing Facility Services for Individuals 21 or over	○	◘[7]	○[5]	○	◘[8]
Nurse Midwife services	○	○	○[5]	●	○
Rural health clinic (RHC) services	○	○	○	○	○

Key: ● = service covered; ◘ = service covered with limitations; ○ = service not covered

[1] All services in the U.S. Virgin Islands must be provided in health department facilities (including FQHCs and referral facilities located off-island) that are pre-approved by the Medicaid program.
[2] Laboratory and x-ray services require prior approval.
[3] Ambulance services are covered when appropriate. Off-island transportation is not covered.
[4] No transportation services are covered on-island; transportation off-island must be pre-approved.
[5] Service not provided because of a lack of qualified local providers. However, these services are covered off-island when the patient is referred off-island to receive them.
[6] Certified nurse practitioner services are not covered as a separate entity, but are covered if they are provided in a Medicaid-certified facility or program.
[7] Long-term or transitional care provided on a case-by-case basis in hospital wards.
[8] The U.S. Virgin Islands has one nursing facility with 80 beds, 20 of which are Medicaid certified. No other nursing facility services are available.

Source: Table prepared by CRS based on data from the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations, Office of Legislation and Planning, June 2008 and the Government Accountability Office, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, (Washington: GPO 2005).

TABLE 12-7--SELECTED OPTIONAL MEDICAID SERVICES COVERED BY THE TERRITORIES, Fiscal Year 2008

Covered Service	American Samoa	Guam	Northern Mariana Islands	Puerto Rico	U.S. Virgin Islands1
Transportation	●	●	●	◘[1]	●
Home Health	●[3]	●	●	○	○
Outpatient Prescription Drugs	●	●	●	●	●
Dental	●	●	●	●	○
Clinic	●	●	●	●	○
Prosthetic Devices	●	●	●	●	○
Physical therapy and Related Services	●	●	●	◘	○
Inpatient Psychiatric Hospital Services for Individuals under age 21	○	○	○	○	○
Personal Care	○	○	○	○	○
Diagnostic, Screening, Preventive	●	○	○	●	○
Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)	○	○	○	○	○
Targeted Case Management (Home and Community Health)	○	○	○	○	○
Hospice Care	○	○	○	○	○
Inpatient Hospital and Nursing Facility Services for Individuals Age 65 and Over in an Institution for Mental Disease (IMD)	○	○	○	○	○
Private Duty Nursing	●[3]	○	○	○	○
Podiatrist Services	●[3]	●		◘	○
Optometrist Services	●[3]	●	●	◘[2]	●
Occupational	●	●	●	●	○
Speech Therapy	●[3]	●	○	●	○

Key: ● = service covered; ◘ = service covered with limitations; ○ = service not covered

[1] Limited to ambulances.
[2] Limited to vision evaluations and exams.
[3] Services only available off-island.
Source: Table prepared by CRS based on data from the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations, Office of Legislation and Planning, June 2008 and the Government Accountability Office, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, (Washington: GPO 2005).

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Financing

The State Children's Health Insurance Program (SCHIP), created by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), offers Federal matching funds to States and territories to provide health insurance to certain low-income children. All of the territories have chosen to participate in SCHIP.

Each territory has an approved State plan and will match their Federal program dollars with territory funds. Except for a special rule for funding, SCHIP operates in the territories on the same terms as in the States.

The statute specifies a total annual allotment for the States, the District of Columbia, and the territories for fiscal years 1998 through 2007. From the original appropriated amounts specified in the BBA of 1997, the law set aside 0.25% of SCHIP funds for the five territories, which is divided among them based on statutorily set proportions. American Samoa receives 1.2%, Guam receives 3.5%, the Northern Mariana Islands receives 1.1%, Puerto Rico receives 91.6%, and the U.S. Virgin Islands receives 2.6%. Funds have been added to the total annual appropriation earmarked for the territories for each year beginning in fiscal year 1999 (see Table 12-8).[20]

The 110th Congress passed two bills to "reauthorize" SCHIP. These bills provided SCHIP funding for fiscal year 2008 through fiscal year 2012 and made other changes to both SCHIP and Medicaid. Both H.R. 976 and H.R. 3963 were vetoed by the President, with the Congress unable to override these vetoes. In lieu of reauthorization, four continuing resolutions (Public Law 110-92, Public Law 110-116, Public Law 110-137, and Public Law 110-149) provided $5 billion for fiscal year 2008 Federal SCHIP allotments through December 31, 2007. As required by the statute, the territories were awarded $12.5 million to be shared as specified. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, Public Law 110-173) extended the availability of the fiscal year 2008 SCHIP allotment through March 31, 2009 and appropriated $5 billion for fiscal year 2009 allotments, also available through March 31, 2009. This brings the total amount allotted to the territories to $52.5 million for each of fiscal year 2008 and fiscal year 2009 ($12.5 million or 0.25% of the fiscal year 2008/2009 SCHIP appropriation plus $40 million in additional appropriations). The program provides funds at a 65% matching rate to the territories up to their cap.

SCHIP funds not drawn down from a jurisdiction's Federal allotment by the end of each fiscal year generally continue to be available for two additional FYs, providing each jurisdiction a total of three years to draw down its allotment of Federal matching funds for a given fiscal year. For example fiscal year 2007 allotments are available through fiscal year 2009. A jurisdiction must draw down its entire allotment from a given fiscal year before it may access the next year's funding. At the end of the applicable three-year period of availability, unspent allotments are redistributed to other jurisdictions. The redistribution

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[20] The fiscal year 1999 Omnibus Appropriations Act (Public Law 105-277) provided an additional $32 million in appropriations for the territories only for that year. These additional funds brought the fiscal year 1999 SCHIP Federal share available to the territories to $42.67 million. Public Law 106-113 increased the territories' original appropriation for allotment (as specified in the Balanced Budget Act of 1997) to be shared (as specified above) by: $34.2 for each of fiscal years 2000 and 2001; $25.2 million for each of fiscal years 2002 through 2004; $32.4 million for each of fiscal years 2005 and 2006; and $40 million for fiscal year 2007. Additionally, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) appropriated $40 million in additional allotments to the territories for each of fiscal years 2008 and 2009.

rules for the States vary by fiscal year, but for each year that the territories were eligible, all entities received 1.05% of the total amount of funds available for redistribution. Such amounts were divided among them according to the percentages defined in statute for the allocation of the original allotments. Since fiscal year 2005, only jurisdictions that exhausted the relevant allotment within three years were eligible to receive unspent funds from other jurisdictions (See Table 12-8 for amounts made available to the territories through the redistribution process).

TABLE 12-8--SCHIP FINANCIAL PROGRAM INFORMATION FOR TERRITORIES Fiscal Years 1998-2008

	American Samoa		Guam		Northern Mariana Islands		Puerto Rico		U.S. Virgin Islands	
Fiscal Year	Allotment	Reallocation	Allotment	Reallocation	Allotment	Reallocation	Allotment	Reallocation	Allotment	Reallocation
1998	$128,850	$256,222	$375,812	$747,314	$118,113	$234,870	$9,835,550	$19,558,283	$279,175	$555,148
1999	512,250	355,147	1,494,063	1,035,846	469,562	325,551	39,101,750	27,109,556	1,109,875	769,485
2000	538,650	278,011	1,571,063	810,867	493,762	254,844	41,116,950	21,221,544	1,167,075	602,358
2001	538,650	220,377	1,571,062	642,765	493,763	202,012	41,116,950	16,822,085	1,167,075	477,483
2002	396,900	80,970	1,157,625	236,162	363,825	74,222	30,296,700	6,180,697	859,950	175,435
2003	396,900	21,845	1,157,625	63,714	363,825	20,024	30,296,700	1,687,490	859,950	47,331
2004	396,900	0	1,157,625	0	363,825	0	30,296,700	0	859,950	0
2005	510,300	0	1,488,375	0	467,775	0	38,952,900	0	1,105,650	0
2006	545,958	0	1,592,377	0	500,462	0	41,674,794	0	1,182,909	0
2007	630,000	NA	1,837,500	NA	577,500	NA	48,090,000	NA	1,365,000	NA
2008	630,000	145,760	1,837,500	425,760	577,500	133,810	48.090,000	11,142,758	1,365,000	316,279

Notes: Totals that appear in the "Allotment" columns include original Federal allotments as specified by Balanced Budget Act of 1997 (Public Law 105-33), and additional appropriations for the territories as specified by (1) the increased appropriation for the territories in the Omnibus Consolidated and Emergency Supplemental Appropriations Act for fiscal year 1999 (Public Law 105-277); (2) the targeted, increased allotments provided in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into the Omnibus Consolidated Appropriations Act, 2000) (Public Law 106-113); (3) additional allotments to eliminate fiscal year 2006 funding shortfalls provided in the Deficit Reduction Act of 2005 (Public Law 109-171); and (4) the additional appropriations for States' shortfalls of Federal SCHIP funds as provided by the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110-173).

The territories did not receive any fiscal year 2004 and fiscal year 2005 redistributed funds in fiscal year 2007.

For fiscal years 1998-2007 the reallocation totals reflect the amount reallocated after the 3 year period of availability.

Source: Table prepared by CRS based on information from the Centers for Medicare and Medicaid Services (CMS).

Administration of SCHIP Programs in the Territories

All territories have opted to use their SCHIP funds to expand their Medicaid programs. As noted above, the Medicaid programs in the territories operate under a Federal funding cap. Once those caps are exhausted, the territories provide coverage to eligible children with territory-only funds.[21] American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands may use SCHIP funds to cover Medicaid eligible children after their Medicaid Federal caps have been exhausted.[22] By contrast, Puerto Rico is permitted to use SCHIP funds to provide child health coverage to children with no health insurance in families with income eligible between 100% and 200% of the commonwealth poverty level at any time during the year regardless of whether the Federal Medicaid cap has been exhausted.[23] The territories are also different from the 50 States and the District of Columbia in their reporting requirements for their SCHIP Programs. Under rules promulgated by the Department of Health and Human Services (HHS), the territories are exempt from the definition of a "State" for the purposes of the requirements of quarterly statistical reporting. In each of the territories, the benefit package for the SCHIP program is the same as is offered by the Medicaid program.

CONSOLIDATION OF CERTAIN GRANTS FOR TERRITORIES OTHER THAN PUERTO RICO

Public Law 95-134 authorized any Federal agency to consolidate grants for the territories of American Samoa, Guam, the Northern Mariana Islands and the U.S. Virgin Islands. Each of these territories is permitted to submit a single application and is paid a single sum that could be expended on any purpose allowable under any of the programs in the consolidated grant. The areas are permitted to determine the proportion of the consolidated grant to be spent on various activities. Public Law 95-134 also permits the administering agency to waive matching and application or reporting requirements.

HHS permits these territories to consolidate up to 22 grant programs, including the Social Services Block Grant, Maternal and Child Health, child welfare services, and Child Abuse and Neglect State Grants. HHS permits these

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[21] Under an interpretation of the law by the U.S. Department of Health and Human Services, funds provided by SCHIP to expand Medicaid programs do not count against the caps on Medicaid funding.

[22] This is under the Centers for Medicare and Medicaid Services' interpretation of section 2110(b)(3) of the Social Security Act that waives the rule that SCHIP funds can be used only for children ineligible for Medicaid or group health plan if that coverage was provided by a health insurance program that was in operation before July 1, 1997, and received no Federal funding.

[23] Under SCHIP, States are permitted to use Federal enhanced matching funds to cover children with no health insurance in families with income that is above the Medicaid eligibility levels that were in place at the time of enactment. This Federal requirement is referred to as the SCHIP maintenance of effort (MOE) requirement. In Puerto Rico prior to the enactment of SCHIP, most children received coverage under the public health system. Because such care was paid for by commonwealth-only funds this financing arrangement does not contradict the rules established under SCHIP's maintenance of effort requirement.

areas to submit a single report in lieu of individual reports required for the individual programs.

CERTAIN TAX PROVISIONS THAT AFFECT LOW-INCOME FAMILIES WITH CHILDREN

Residents of Puerto Rico are exempt from the Federal personal income tax, and hence are not eligible for tax provisions that affect low-income families with children such as the earned income tax credit (EITC) and the dependent care tax credit (DCTC). Residents of the other territories also do not pay Federal personal income taxes. However, residents of Guam, the Northern Mariana Islands and the U.S. Virgin Islands benefit from the EITC and the DCTC of the Federal Tax Code because their territorial tax systems "mirror" the Federal income tax. Territories generally use the Federal income tax system as their own, though residents pay their taxes to the territory and not the Federal government. Federal law requires the U.S. Virgin Islands to use the Federal income tax system as the territorial tax system. American Samoa, Guam and the Northern Mariana Islands are also required to mirror the Federal income tax unless they execute an agreement with the Treasury Department meeting conditions required to establish an independent tax system. Only American Samoa has executed such an agreement.

The corporate Tax Code includes two tax credits offered to employers who hire welfare recipients: the work opportunity tax credit and the welfare-to-work tax credit enacted in the Taxpayer Relief Act of 1997 (Public Law 105-34). U.S. chartered corporations operating in the territories are eligible for these two credits because the Federal corporate tax is levied on their worldwide income.

Corporations chartered in territories are considered "foreign" corporations under the Federal Tax Code. Therefore, companies chartered in Puerto Rico would not benefit from Federal tax credits for employers that hire welfare recipients. However, companies chartered in Guam, the Northern Mariana Islands and the U.S. Virgin Islands that operate under mirror tax systems benefit from these credits under territorial tax systems.

REFERENCES

Bureau of the Census, *Consolidated Federal Funds Report for FY2007,* (Washington: GPO 2008).

Government Accountability Office, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, (Washington: GPO 2005).